- 5. Exemplary Damages in the amount of five-hundred and fifty thousand dollars (\$550,000) from each Defendant to PLAINTIFF as an enhancement of compensatory damages because of the maliciousness, wanton, reckless, and oppressive character of the acts described herein, and to punish and deter other state employees acting under color of law from committing these or similar acts.
- 6. Mental Anguish Damages in the amount of five-hundred and fifty thousand dollars (\$550,000) from each Defendant to PLAINTIFF for mental suffering resulting from the events set forth herein.
- 7. Nominal Damages in the amount of five-hundred and fifty thousand dollars (\$550,000) from each Defendant to PLAINTIFF which PLAINTIFF is entitled to because the law may infer the damages from the breach of an agreement or the invasion of a Constitutional right in light of the facts described herein.
- 8. Punitive Damages in the amount of five-hundred and fifty thousand dollars (\$550,000) from each Defendant to PLAINTIFF as an enhancement of compensatory damages because of the maliciousness, wanton, reckless, and oppressive character of the acts described herein, and to punish and deter other state employees acting under color of law from committing these or similar acts.
- 9. Appointment of Counsel as PLAINTIFF is a layperson and unskilled at law and was compelled to seek the assistance from a fellow prisoner (William Milton, CDCR# P-38650, who is also a layperson and unskilled at law), to assist in drafting, filing and prosecuting the instant complaint in this Court.
 - 10. Economic and non-economic Damages.

- 11. Medical and Related Expenses, according to proof.
- 12. Lost Earnings, past and future.
- 13. Costs of Suit incurred herein.
- 14. Interest, as allowed by law.
- 15. Attorney's Fees and Costs
- 16. An order directing the U.S. Marshal to serve the named-Defendants including waiver of any and all processing/service and additional fees.
 - 17. Other such and further relief as the Court may deem proper.

VERIFICATION

Pursuant to 28 U.S.C. §1746, I, Joel Nunez, read the foregoing Civil Rights complaint and declare under penalty of perjury that all statements made herein are true and correct to the best of my knowledge, information and belief.

Signature of Declarant: Toel None





STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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STATE OF CALIFORNIA

HEALTH CARE SERVICES REQUEST FORM

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STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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	D AFTER PATIENT'S APPOINTMENT
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STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

PART I: TO BE COMPLETED BY THE PATIENT
A fee of \$5.00 may be charged to your trust account for each health care visit.
If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.
REQUEST FOR: MEDICAL → MENTAL HEALTH → DENTAL → MEDICATION REFILL →
NAME / 1 CDC NUMBER HOUSING
Nunez, Joe/ K-63350 EW-319UP
PATIENT SIGNATURE DATE
PATIENT SIGNATURE Joel North 2-24-14
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The Problem)
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NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM-ON-
BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM
PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT
Visit is not exempt from \$5.00 copayment. (Send pink copy to Inmate Trust Office.)
PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE
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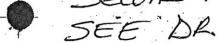
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STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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	PART I: TO BE TO	MPLETED BY THE PATIENT	
	A fee of \$5.00 may be charged to	your trust account for each health care vi.	sit.
If you believe	this is an urgent/emergent hea	Ith care need, contact the correction	al officer on duty.
REQUEST FOR: ME	DICAL MENTAL H	IEALTH ☐ DENTAL ☐	MEDICATION REFILL □
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☐ Visit is not exempt from	\$5.00 copayment. (Send pin	k copy to Inmate Trust Office.)	
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STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

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PART I: TO BE COMPLETED BY THE PATIENT	
A fee of \$5.00 may be charged to your trust account for each health care visit.	
If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.	
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NUNEL, JOEL K-63350 F-W- 321 4	
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☐ Visit is not exempt from \$5.00 copayment. (Send pink copy to Inmate Trust Office.)	
PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE	
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0:10:10 P: + R: D BP: 105/54 WEIGHT: 189 185	
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APPOINTMENT EMERGENCY URGENT ROUTINE	
SCHEDULED AS: (IMMEDIATELY) (WITHIN 24 HOURS) (WITHIN 14 CALENDAR DAYS)	
REFERRED TO PCP: DATE OF APPOINTMENT:	
COMPLETED BY) A A D NAME OF INSTITUTION	
Wa'llw I	0
PRINT/STAMP NAME SIGNATURE / TITLE DATE/TIME-COMPLETED	y
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STATE OF CALIFORNIA CDC-7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

PART I: TO BE COMPLETED BY THE PATIENT
A fee of \$5.00 may be charged to your trust account for each health care visit.
If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.
REQUEST FOR: MEDICAL MENTAL HEALTH DENTAL MEDICATION REFILL
NUNEZ, Joel K-63350 Housing Y-W-120 UP
PATIENT SIGNATURE Joel Nung DATE 1-30-11
REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) I need to See the OCTOR. The Medication
he prescribe me, Is not working. I am
in pain at this moment, I have actritis in my
NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON
BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT
Visit is not exempt from \$5.00 copayment. (Send pink copy to Inmate Trust Office.)
PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE
Date / Time Received: Received by:
Date / Time Reviewed by RN: Reviewed by:
S: (Pain/Scale: 1 2, 3 4 5 6 7 8 9 10
(1) Knee pain ald symptons
0109: 97 P: 64 R: 20 BP: 120 68 WEIGHT: 14 4 (165)
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A: Alteration i confitte O knee diswifat.
□ See Nursing Encounter Form
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E: It felist to be on samsol 1
APPOINTMENT EMERGENCY URGENT ROUTINE SCHEDULED AS: (IMMEDIATELY) (WITHIN 24 HOURS) (WITHIN 14 CALENDAR DAYS)
REFERRED TO PCP: DATE OF APPOINTMENT:
COMPLETED BY NAME OF INSTITUTION
PRINT/STAMP NAME SIGNATURE XTITLE DATE/TIME COMPLETED 22 1
CDC 7362 (Rev. 03/04) Original - Unit Health Record Yellow - Inmate (if copayment applicable) On Prince Trust Office (if copayment applicable) 55 Gold Inmate







Plane 1212

STATE OF CALIFORNIA CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

CDC 7362 (Rev. 03/04)	HEALI	I CARE SER	VICES REQ	OESI FOR	KIVI	
	PART	I: TO BE COM	PLETED BY TH	IE PATIENT		
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REQUEST FOR:	MEDICAL 🗹	MENTAL HE	ALTH	DENTAL	MEDICATION	REFILL 🗌
NAME NUNEZ,	JoEL	CDC NUMBER		ŀ	HOUSING Y-W-120	, up
PATIENT SIGNATURE					DATE	
Toek	Nona				12-16-10	
REASON YOU ARE R	ed to s	FE The	ES. (Describe Your	Health Problem	UE ACTR	ave Had
IN MY SP	INE LOW	IER BAC	R PAIN.	ALSOZ	CHAVE COL	<u>8</u>
Symtoms	·Thanc	4 you.				
NOTE: IF THE PATIEN BEHALF OF THE PATIE			, A HEALTH CARE	STAFF MEMBER	R SHALL COMPLETE TI	HE FORM ON
٨٨	PART III: TO B	E COMPLETED	AFTER PATIEN	IT'S APPOIN	TMENT	
Visit is not exemp	ot from \$5.00 copay	ment. (Send pink	copy to Inmate Tr	ust Office.)		
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Date / Time Reviewed by	PN. 12/17/	10	Reviewed by:	MIX		\sim
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